IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

PFLAG, INC., et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Civil Action No. BAH-25-337

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association ("APA"), the American Academy of Child & Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Pediatric Society ("APS"), the Association of American Medical Colleges ("AAMC"), Association of Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Maryland Chapter of the American Academy of Pediatrics ("MDAAP"), the Endocrine Society ("ES"), the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Society for Adolescent Health and Medicine ("SAHM"), the Society of Pediatric Nurses ("SPN"), and the World Professional Association for Transgender Health ("WPATH") (collectively, "*Amici*") makes the following disclosures:

1. No publicly held corporations hold any stock in AAP, APA, AACAP, AAFP, AAN, ACOG, ACOP, ACP, APS, AAMC, AMSPDC, MDAAP, ES, NAPNAP, PES, SAHM, SPN, or WPATH.

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INTRODUCTION

On January 28, 2025, President Donald Trump signed Executive Order No. 14187 (the "Healthcare Ban"), directing all federal agencies to "immediately take appropriate steps to ensure that institutions receiving Federal research or education grants end" gender-affirming medical care for people under nineteen, which as this brief describes is critical, medically necessary, evidence-based care for gender dysphoria.[1] Effectively denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents that is targeted in the Healthcare Ban.

Gender dysphoria is a condition that is characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth.[2] If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. As such, the effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating here as *amici*, widely recognizes that the appropriate protocol for treating gender dysphoria in

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[1] In this brief, the term "gender-affirming medical care" refers to the use of gonadotropin-releasing hormone (GnRH) analogues and/or hormone therapy to treat gender dysphoria. Because this brief focuses primarily on adolescents, it does not discuss surgeries that are typically available to transgender adults, nor does it discuss the treatment guidelines for gender dysphoria in transgender adults affected by the Healthcare Ban.

[2] *See, e.g.*, Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) Pediatrics e20182162, at 2–3 tbl.1 (2018), https://perma.cc/DB5G-PG44 [hereinafter, "AAP Policy Statement"]. The American Academy of Pediatrics voted to reaffirm the AAP Policy Statement. See Alyson Sulaski Wyckoff, Am. Acad. of Pediatrics, *AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update*, AAP News (Aug. 4, 2023), https://perma.cc/XS4B-WBLH. In addition, AAP has commissioned a systematic review of the existing research, which is part of its normal procedures to perform such reviews on a periodic basis to maintain up-to-date guidelines.

transgender adolescents is "gender-affirming care."[3] Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.[4] For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria.[5]

The Healthcare Ban disregards this medical evidence by effectively denying adolescents' access to treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to grant Plaintiffs' motion for a preliminary injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects inaccuracies regarding the professionally-accepted medical guidelines for treating gender dysphoria and explains how the Healthcare Ban would irreparably harm

[3] *Id*. at 10.
[4] *See, e.g.*, Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), https://perma.cc/HXY3-UX2J.
[5] *See* Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579, at 2 (2021), https://perma.cc/BR4F-YLZS (providing an overview of the scientific basis underlying gender-affirming care and its demonstrated effectiveness in "alleviat[ing] gender dysphoria").

adolescents with gender dysphoria by effectively denying access to crucial care for those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

Gender identity refers to a person's deep internal sense of belonging to a particular gender.[6] Most people are "cisgender:" meaning they have a gender identity that aligns with their sex assigned at birth.[7] However, transgender people have a gender identity that does not align with their sex assigned at birth.[8] In the United States, approximately 1.6 million individuals identify as transgender.[9] Of these individuals, approximately 10% are teenagers aged 13 to 17.[10] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing acceptance of being transgender as a normal variation of human identity.[11] However, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life."[12] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR).[13]

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[6] AAP Policy Statement, *supra* note 2, at 2 tbl.1.
[7] *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 861–862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.
[8] *See id.* at 863.
[9] *See* Jody L. Herman et al., *How Many Adults and Youth Identify as Transgender in the United States?*, Williams Inst., at 2 (June 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf.
[10] *See id.* at 3.
[11] James L. Madara, *AMA to States: Stop Interfering in Healthcare of Transgender Children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; *see also* Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.
[12] AAP Policy Statement, *supra* note 2, at 5.
[13] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); *see also* World Health Org., International Classification of Diseases, Eleventh Revision (ICD-11) (2019/2021) (continued…)

If untreated or inadequately treated, gender dysphoria may lead to depression, anxiety, self-harm, and suicidality.[14] In contrast, with treatment, transgender adolescents with gender dysphoria can mature into thriving adults.[15]

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Gender-Affirming Medical Care When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, puberty blockers and hormone therapy are necessary.[16] Gender-affirming care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[17]

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Gender-Affirming Medical Care.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender Diverse People (together, the "Guidelines").[18]

("Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.").

[14] *See* Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASSOC. NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668.

[15] *See infra* Section II.C.

[16] *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020), https://www.endocrine.org/advocacy/position-statements/ transgender-health.

[17] *See id.*

[18] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) ("Endocrine Soc'y Guidelines"), https://academic.oup.com/jcem/article/102/11/ 3869/4157558; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8thVersion) ("WPATH Guidelines"), https:// www.tandfonline.com/doi/pdf/10.1080/ 26895269.2022.2100644.

The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional ("HCP").[19] Further, the Guidelines provide that each patient who receives gender-affirming care should receive only medically necessary and appropriate care that is tailored to the patient's individual needs and that is based on the best evidence possible along with clinical experience.[20]

1. The Guidelines Do Not Recommend Gender-Affirming Medical Care for Prepubertal Children.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning.[21] The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive puberty blockers, hormone therapy, or surgeries.[22]

2. A Robust Diagnostic Assessment Is Required Before Gender-Affirming Medical Care Is Provided.

In contrast to prepubertal children, the Guidelines do contemplate the possibility that, for some transgender adolescents with gender dysphoria, gender-affirming medical care may be indicated, provided certain criteria are met. According to the Guidelines, puberty blockers and hormone therapy should be provided only after a thorough evaluation by a HCP who: (1) is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical

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[19] *See infra* Section II.A.2.
[20] *See* WPATH Guidelines, *supra* note 18, at S16–S18; Endocrine Soc'y Guidelines, *supra* note 18, at 3872–73.
[21] *See* WPATH Guidelines, *supra* note 18, at S73–S74; Endocrine Soc'y Guidelines, *supra* note 18, at 3877–78. "Social transition" refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm. *See, e.g.*, WPATH Guidelines, *supra* note 18, at S75.
[22] *See* WPATH Guidelines, *supra* note 18, at S64, S67; Endocrine Soc'y Guidelines, *supra* note 18, at 3871.

field; (2) has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; (3) has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to consent, and possesses knowledge about gender diversity across the life span; (4) has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and (5) continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families.[23]

Prior to developing a treatment plan, the HCP should conduct a robust diagnostic assessment—specifically, a "comprehensive biopsychosocial assessment"—of the adolescent patient.[24] The HCP conducts this assessment to "understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs," so that the resulting treatment plan is appropriately individualized.[25] This assessment must be conducted collaboratively with the patient and their caregiver(s).[26]

3. In Certain Circumstances, the Guidelines Provide for the Use of Gender-Affirming Medical Care to Treat Adolescents With Gender Dysphoria.

For youth with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental health care, gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, a qualified HCP must make a determination that such medical care is indicated. The Guidelines collectively provide that, before prescribing puberty blockers,

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[23] *See* WPATH Guidelines, *supra* note 18, at S49.
[24] *Id.* at S50.
[25] *Id.*
[26] *Id.*

the HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy;[27] (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.[28] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.[29]

If all the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[30] The purpose of puberty blockers is to delay the development of permanent secondary sex characteristics—which may result in significant distress for transgender youth—until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.[31] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily

[27] Endocrine Soc'y Guidelines, *supra* note 18, at 3876; WPATH Guidelines, *supra* note 18, at S47, S48.
[28] WPATH Guidelines, *supra* note 18, at S59–65.
[29] Endocrine Soc'y Guidelines, *supra* note 18, at 3878 tbl.5.
[30] WPATH Guidelines, *supra* note 18, at S61–62, S64; Endocrine Soc'y Guidelines, *supra* note 18, at 3878 tbl.5; Martin, *supra* note 5.
[31] WPATH Guidelines, *supra* note 18, at S112.

changes such as protrusion of the Adam's apple or breast growth.[32] Puberty blockers have well-known efficacy and side-effect profiles.[33] Their effects are generally reversible, and when a patient discontinues their use, the patient resumes endogenous puberty.[34] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[35] The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision.[36]

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[37] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[38] Hormone therapy is only prescribed when a qualified mental health professional has confirmed: the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed.[39] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents must be informed of the potential effects and side effects and give their informed consent.[40] Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics

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[32] *See* AAP Policy Statement, *supra* note 2, at 5.
[33] *See* Martin, *supra* note 5, at 2.
[34] *See id.*
[35] *See* F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEJM 1546 (1981).
[36] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi. nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).
[37] Martin, *supra* note 5, at 2.
[38] *See* AAP Policy Statement, *supra* note 2, at 6.
[39] Endocrine Soc'y Guidelines, *supra* note 18, at 3878 tbl.5.
[40] *See id*.

are fully developed, others are partially reversible if the patient discontinues use of the hormones.[41]

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks.[42] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents, and the medical and mental health care team. There is "no one-size-fits-all approach to this kind of care."[43]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other guidelines promulgated by *amici* and other medical organizations with respect to other areas of medicine, such as treatments for cancer, diabetes, or cardiovascular disease.

For example, the Endocrine Society Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.[44] The Endocrine Society imposed strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[45] That GRADE assessment was then reviewed, re-reviewed, and reviewed again by independent groups of professionals.[46]

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[41] *See* AAP Policy Statement, *supra* note 2, at 5–6.
[42] *See* Endocrine Soc'y Guidelines, *supra* note 18, at 3871, 3876.
[43] Martin, *supra* note 5, at 1.
[44] *See, e.g.*, Endocrine Soc'y Guidelines, *supra* note 18, at 3872–73.
[45] *See* Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://ahpsr.who.int/docs/librariesprovider11/publications/supplementary-material/hsr-synthesis-guyatt-2011.pdf; Gordon H. Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, 336 BMJ 924 (2008), https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC2335261.
[46] Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology.

Reviewers were subject to strict conflict of interest rules, and there was ample opportunity for feedback and debate through the years-long review process.[47] Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.[48]

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.[49] The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.[50] There were 119 authors ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families.[51] Each recommendation in the Standards of Care was formally approved using the Delphi process,[52] which is one of the most commonly adopted consensus development strategies for medical clinical practice guidelines.[53]

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-being.[54] A number of studies have been published that investigated the use of puberty blockers on adolescents with

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[47] *See id*.
[48] *See* Endocrine Soc'y, Endocrine Soc'y Statement in Support of Gender-Affirming Care (May 8, 2024), https://perma.cc/J4Y2-RUJ2.
[49] *See* WPATH Guidelines, *supra* note 18, at S247-51.
[50] *See id*.
[51] *See id.* Inclusion of input from the relevant patient population during development of medical guidelines adheres to national standards and best practices. *See* National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 89–92 (2011).
[52] *See* WPATH Guidelines, *supra* note 18, at S247-51.
[53] *See* National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 88 (2011).
[54] *See* Martin, *supra* note 5, at 2.

gender dysphoria,[55] and/or the use of hormone therapy to treat adolescents with gender dysphoria.[56] These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.[57]

For example, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment.[58] A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated

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[55] *See, e.g.*, Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Wellbeing of Transgender Youths*, 8 INT'L J PEDIATRIC ENDOCRINOLOGY 1–5 (2020), https://pubmed.ncbi.nlm.nih.gov/ 32368216; Polly Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People With Persistent Gender Dysphoria in the UK*, 16(2) PLOS ONE e0243894 (2021), https:// pubmed.ncbi.nlm.nih.gov/33529227; Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12(11) J. SEXUAL MED. 2206–2214 (2015), https:// pubmed.ncbi.nlm.nih.gov/26556015; Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder*, 8(8) J. SEXUAL MED. 2276–2283 (2011), https://pubmed.ncbi.nlm.nih.gov/ 20646177; Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696–704 (2014), https:// pubmed.ncbi.nlm.nih.gov/25201798; Laura E. Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) PEDIATRICS e20193006 (2020), https://pubmed.ncbi.nlm .nih.gov/32220906; Jack L. Turban et al., *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, 145(2) PEDIATRICS e20191725 (2020), https:// www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269; Anna I.R. van der Miesen, *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*, 66(6) J. ADOLESCENT HEALTH 699–704 (2020); Diana M. Tordoff et al., *Mental Health Outcomes In Transgender And Nonbinary Youths Receiving Gender-Affirming Care*, 5(2) JAMA NETWORK OPEN e220978 (2022), https:/pubmed.ncbi.nlm.nih.gov/ 35212746/.

[56] *See, e.g.*, Achille, *supra* note 55; Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7(3) CLINICAL PRAC. PEDIATRIC PSYCH. 302 (2019), https://psycnet.apa.org/record/2019-52280-009; Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEJM 240–250 (2023); Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93(1) ANALES DE PEDIATRIA 41–48 (English ed. 2020), https://www.researchgate.net/publication/342652073; Vries, *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, *supra* note 55; Rittakerttu Kaltiala et al., *Adolescent Development And Psychosocial Functioning After Starting Cross-Sex Hormones For Gender Dysphoria*, 74(3) NORDIC J. PSYCHIATRY 213 (2020); Kuper, *supra* note 55; Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. ADOLESCENT HEALTH (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext; Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), https://journals.plos.org/plosone/article?id=10.1371/ journal.pone.0261039.

[57] The data likewise indicates that adults who receive gender-affirming care experience positive mental health outcomes. *See, e.g.*, Zoe Aldridge et al., *Long Term Effect of Gender Affirming Hormone Treatment on Depression and Anxiety Symptoms in Transgender People*, 9 ANDROLOGY 1808–1816 (2021).

[58] *See* Allen, *supra* note 56.

with decreased symptoms of depression and anxiety.[59] Additionally, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.[60] The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[61] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[62]

Further, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[63] A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.[64] "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population."[65]

As clinicians and scientific researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming medical care targeted in the Healthcare Ban is effective for the treatment of gender dysphoria.

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[59] *See* Chen, *supra* note 56.
[60] *See* Turban, *supra* note 55.
[61] *See id*.
[62] *See id.*
[63] *See* Vries, *Puberty Suppression in Adolescents with Gender Identity Disorder*, *supra* note 55.
[64] Vries, *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, *supra* note 55.
[65] Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

III. The Healthcare Ban Relies on Factually Inaccurate Claims and Ignores the Recommendations of the Medical Community.

In attempting to justify effectively denying access to gender-affirming medical care, the Healthcare Ban makes claims which are factually incorrect and contradicted by the available scientific evidence. In particular, the Healthcare Ban states that "[c]ountless children soon regret" receiving gender-affirming medical care. Exec. Order No. 14187 § 1. The Healthcare Ban improperly conflates prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical care targeted in the Healthcare Ban.[66] The Guidelines endorse the use of this medical care only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met.[67]

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not.[68] On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."[69]

Moreover, while detransitioning may occur for many reasons, detransitioning is not the same as regret. The Healthcare Ban incorrectly assumes that an individual who detransitions—the definition of which varies from study to study[70]—must do so because they have come to

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[66] *See* Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims*, 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374.
[67] *See* Endocrine Soc'y Guidelines, *supra* note 18, at 3871, 3879; WPATH Guidelines, *supra* note 18, at S32, S48.
[68] *See, e.g.*, Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Non-Conformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211.
[69] Rosenthal, *supra* note 65, at 585.
[70] Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly* (continued…)

identify with their sex assigned at birth. This ignores other, more commonly reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination.[71]

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low—only 1.8% of high-school students identify as transgender,[72] and only a small fraction of transgender adolescents are prescribed gender-affirming medical care.[73] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.[74]

IV. The Healthcare Ban Would Irreparably Harm Many Adolescents with Gender Dysphoria By Effectively Denying Them Access to the Treatment They Need.

The Healthcare Ban effectively denies adolescents with gender dysphoria in Maryland and throughout the United States access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care targeted in the Healthcare Ban can be a crucial part of treatment for transgender adolescents with gender dysphoria and necessary to preserve their health. Clinicians who are members of the relevant *amici* associations have witnessed the

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Complex Phenomenon, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), https://pubmed.ncbi.nlm.nih.gov/35678284 ("Detransition refers to the stopping or reversal of transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.").

[71] *See id.* (discussing "largest study to look at detransition").

[72] *See* Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, HHS/CDC, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 68 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf.

[73] Landon D. Hughes, Brittany M. Charlton, Isa Berzansky, *Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022*, JAMA Pediatr. (Jan. 6, 2025), https://pubmed.ncbi.nlm.nih.gov/39761053/ (finding that less than 0.1% of transgender adolescents are prescribed puberty blockers or hormone therapy by examining private insurance claims over 5 years)

[74] *See* Boulware, *supra* note 66, at 20.

benefits of this treatment as well as the harm that results when such treatment is denied or delayed.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[75] In light of this evidence supporting the connection between lack of access to gender-affirming medical care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' motion for a preliminary injunction.

[75] *See* M. Hassan Murad et al., H*ormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban, *supra* note 55.

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CERTIFICATE OF SERVICE

I hereby certify that on February 21, 2025, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record.

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